

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUL 16 1934

Pomona Hospital

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

24312

1. PLACE OF DEATH

County Howell
Township Dry Creek
City Pomona (No.)

Registration District No. 387
Primary Registration District No. 33-40

File No.
Registered No.
St. Ward

2. FULL NAME

Issac Newton Holliday

(a) Residence. No. St. Ward.
(Usual place of abode)
(If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Julia Holliday

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 21 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 10 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steep Jack
(b) General nature of industry, business, or establishment in which employed (or employer) Painter
(c) Name of employer Peveers Dairies Co

9. BIRTHPLACE (CITY OR TOWN) West Plains
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER J. N. Holliday
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Jane Allen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. C. H. Palmer
(Address) 192 North Florence Ave. Oberlin

15. FILED July 7 1934 Bessie L. Serrey
REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 2, 1934

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1934, to July 2, 1934, that I last saw him alive on July 2, 1934, and that death occurred, on the date stated above, at 3:10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Basilar fracture
(Fracture skull laceration
brain from fall)
(duration) yrs. mos. ds. 2

CONTRIBUTORY (SECONDARY) meningitis
(duration) yrs. mos. ds. 1

18. WHERE WAS DISEASE CONTRACTED Cabool Mo
IF NOT AT PLACE OF DEATH 14

19. DID AN OPERATION PRECEDE DEATH? no DATE OF —

20. WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical findings
(Signed) D. C. O., M. D.

7-2-1934 (Address) Pomona Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

National Cemetery - Springfield July 16 1934

20. UNDERTAKER Hermana L. Lomax ADDRESS Springfield Mo

DEC 2 1952

#2
HowellDEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSE. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Isaac Newton Holliday
Who died at _____ on July - 2 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex M Color or race W Single ☒ married, widowed or divorced: _____

Date of birth _____ Age: Years 35 Months 10 Days 11

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: Basilar Fracture 1866

Other contributory causes of importance Meningitis
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (~~violence~~) fill in also the following:
Accident, ~~suicide~~, or homicide? _____ Date of injury June 30, 1934
Where did injury occur? Capeol, Missouri Texas, County
(Specify city or town, county and State)

Specify whether injury occurred in industry, in ~~home~~, or in ~~public place~~.

Manner of injury _____
Nature of injury Fell while painting smoke stack for Pevely Dairy Co.
Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

Name of physician D. D. Coor M.D.
Address of physician Domina
Signature of Registrar Benie L. Scruggs Date filed Sept 7 - 1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 387

Very truly yours,

Primary Reg. Dist. No. 5540

E. T. McGaugh, M.D.
Special Agent.

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